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Rethinking Canada's Unbalanced Mix of Public and Private Healthcare: Insights from Abroad

International experience suggests that private care options can push improvements in universal public health systems. Should Canada follow suit?

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The Study In Brief

Roughly 30 percent of all Canadian healthcare is privately paid for, about the same proportion as the average for the 34 industrialized countries that are members of the Organisation for Economic Co-operation and Development (OECD). However, two things make Canada's public-private mix unique. On the one hand, there is rather limited public coverage for items such as outpatient drugs, long-term care, and dental and vision care. But on the other hand, government pays for virtually all services delivered by physicians and acute-care hospitals.

With limited government budgets for healthcare, these Canadian distinctions are linked: more spending on hospitals and doctors means there is less money for other areas of healthcare. In other countries, the public-private financing mix is typically more balanced, with government plans paying for a larger share of drugs, dental and continuing care, but with more private financing for hospital and physician services.

In face of widespread calls for Canadian governments to expand public coverage for services such as drugs and homecare, policymakers must confront challenging trade-offs that rest on increasing taxes to help pay for these additional benefits. In this *Commentary*, we argue that a major contributing factor to Canada's unbalanced public-private healthcare mix are the unique restrictions that many provinces impose on the private financing of hospital and physician care. Many health systems in Europe and elsewhere do not have similar restrictions and devote a much larger share of public resources to drugs and long-term care while still operating equitable and high-performing healthcare systems.

Relaxing provincial regulations on physicians' private income sources, such as opt-out prohibitions, limits on fees, and private insurance bans, could build on the strengths of our current system. Expanded patient choice and competition from healthcare providers outside medicare would create incentives for politicians and bureaucrats to manage the public system more efficiently.

This *Commentary* also examines the *Canada Health Act's* restrictions on the basic principles of our universal provincial health insurance plans. It describes the more pluralistic approaches to healthcare financing and production among other countries whose systems have been ranked well above ours in both efficiency and equity dimensions.

Canada's single-payer model for hospitals and doctors may be less expensive to administer than a pluralistic one with both public and private payment. However, a single-payer system in which doctors are expected to always use the best available medical care for every patient ultimately creates an impossible dilemma, as advancing medical technology raises the cost of doing so. Our single-payer system may have led to more equal healthcare between rich and poor than would have prevailed otherwise, but it arguably has made the social policy debate focus too much on healthcare to the detriment of other programs that are at least as important in helping society's most vulnerable.

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When Canadians read about the bitter political battles over the Obama administration's health policy initiatives, most feel fortunate by comparison.

The Americans are still struggling to come closer to a goal that we attained over 40 years ago – that every resident should have access to healthcare regardless of ability to pay. Moreover, our healthcare system has accomplished this goal even though our spending on healthcare is a much lower proportion of GDP than in the US. In the Canadian political arena, even those who generally favour a limited role for government in the economy typically accept that our provincial medicare plans do a better job delivering efficient and equitable care than the American system in which private payment and production still predominate.

It is hard to disagree with this view. However, the popular debate over health policy in Canada has historically been far too concerned with the superiority of our system over the American one. If one looks instead at how we compare with countries in Europe and elsewhere, the picture is less favourable. A recent international ranking of 12 industrial countries' healthcare systems places Canada close to the bottom (Commonwealth Fund 2014). Our low placement partly reflects what is not covered by our provincial plans (notably outpatient pharmaceuticals), but it also demonstrates that even though we spend large amounts of public funds on hospital and physician services, patients in many provinces still have difficulties in accessing primary care or face long waits for specialist consultations and certain kinds of surgery.

Over the last few decades, there has been no shortage of proposals for reforms – such as changing the way in which we pay hospitals and doctors, loosening regulations on physicians' scope of practice and providing a greater role for competition within the public system – that could help us control costs and get better value. Some of these suggestions have been inspired by reforms undertaken in Europe and have even been acted upon, to a limited extent, in a few provinces. But while some of these reforms have produced significant system improvements in Europe, there is little evidence that Canada has made significant progress in these respects.[1]

There are many reasons, mostly involving politics, why significant healthcare reform seems so difficult to achieve. One factor is divided responsibility for healthcare financing between the federal and provincial governments. Another is the ability of interest groups in the healthcare sector to block reforms that they perceive as threatening. In this *Commentary*, we argue that a third reason is that lack of competition between provincial health insurance plans and privately financed medicine has lessened the pressure on public-sector managers and politicians to improve an inadequately performing public system.

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1 European-inspired reforms that have been considered for Canada are detailed, for example, in Kirby (2002) or Blomqvist (2002). As well, Bliss (2010) traces the history of Canada's healthcare reform debate.

European countries have shown that it is possible to open their healthcare systems to private medicine without violating the basic commitment to equity that they share with Canada. They have also demonstrated that more competition can create an environment that encourages policymakers to take the hard decisions needed for efficient management. Accordingly, we recommend that provincial governments should relax the restrictions they currently impose on private financing and production of health services outside the provincial plans and allow a greater role for private medicine and insurance.

This recommendation will undoubtedly be considered by many as a dangerous first step on the "slippery slope" that would ultimately erode our commitment to equity. But how great is the danger of this happening? Private medicine and insurance are unlikely to emerge on a significant scale unless there is a reasonably firm political commitment to allow them to do so, and such a commitment will not be made in Canada unless the citizenry is convinced that it can be made without violating the fundamental principles that underpin our version of universal medicare.

A serious discussion about these issues would look at countries with similar healthcare principles as Canada's, like the United Kingdom, Switzerland, the Netherlands and Australia, among others. These countries, like Canada, subscribe to the principle that needed care should be available to all, regardless of ability to pay, but interpret that goal in a way that does not force everyone to get their care through a single government plan. We believe such an open approach is also a way to achieve broader equity objectives, as it will free up public funds for non-health programs that help society's most vulnerable.

The Canadian System: "Narrow but Deep" Public Funding

The data on aggregate Canadian healthcare spending show that about 30 percent is privately paid for, roughly the same as the OECD average (OECD Health Statistics 2014). However, two aspects make Canada's public-private mix unique. On one hand, there is rather limited public coverage for items such as outpatient drugs, long-term care, and dental and vision care. But on the other hand, government pays for virtually all physicians' services and acute-care hospital costs. With a fixed government budget for healthcare, these characteristics are linked – more spending on hospitals and doctors means there is less money for other areas of healthcare.

Elsewhere, the public-private financing mix is typically more balanced, with government plans paying for a larger share of drugs, dental and long-term care, but with more private financing for hospital and physician services.[2] In response, there have been many calls in Canada for more public spending on drugs and other outpatient services (Morgan et al. 2013, Doctors for Medicare 2013). We agree, but add that this would be more likely with a somewhat lower share of government funding of hospital and physician services.

Privatization and the Canada Health Act

The central pillar supporting Canada's public healthcare funding model is the 1984 *Canada Health Act* (CHA). The CHA codifies the requirements provincial health insurance plans must meet as a condition for the health-related transfers the federal government has been making

2 The Canadian pattern is sometimes described as "narrow but deep" coverage; that is, there are big gaps in what is covered, but there is almost 100 percent coverage for the items that are included. We share the view that a more balanced approach would serve Canadians better.

to the provinces since the late 1950s (Bliss 2010). Since healthcare falls under provincial jurisdiction, Ottawa could not start a public health insurance plan on its own (as was done in the US when its federal Medicare plan for retirees was introduced in 1966). The route that Canada's Liberal government took instead in the 1960s was to use its constitutional "spending power" to offer major cash transfers to those provinces that created public health insurance programs that satisfied some of the conditions subsequently set out in the CHA.[3]

Although this is not widely understood, the CHA does not rule out transactions in which providers are paid privately for their services. There is also no prohibition on private insurance that covers the same services as those under the public plans, provided these services are supplied entirely independent of publicly funded services (Boychuk 2012). All the CHA says is that to qualify for federal cash support, the provinces must offer public insurance plans that are "available" to all residents "on equal terms and conditions," among other requirements. While the CHA's intent, and that of the earlier legislation it replaced, was to ensure that *every* provincial resident would automatically have coverage and access to needed services regardless of ability to pay, these requirements were also consistent with some patients paying privately for physician or hospital services outside the provincial plans, and with the availability of private insurance plans that covered the same services as the public plans (Boychuk 2012, 2008).[4]

The CHA differs from its predecessor legislation in that it explicitly rules out "extra-billing"; that is, doctors charging patients over and above the fee they receive for their services from the provincial plans. Since many doctors practised extra-billing before 1984, the concern was that banning it would cause them to give preference to patients with private insurance, or who were willing to pay out of their own pocket, because they could be charged more. To prevent this, many provinces – over and above the requirements of the CHA – introduced laws and regulations to discourage private insurance and service provision outside of the public plans (Boychuk 2008, Bliss 2010).

Provinces limit, to varying degrees, the opportunities for private insurance and for private practice outside the provincial plans through regulations regarding physicians opting out of the public plans, limits on fees, bans on private insurance or direct patient billing, etc. (Boychuk 2008).[5] As a result of these restrictions, privately supplied hospital and physician services have become a negligible part of most provinces' healthcare systems, even in New Brunswick and PEI where the restrictions are somewhat more relaxed (see Table 1).

Canada's provinces implemented these restrictions on private insurance and service provision as a way to ensure that the public plans

3 In Saskatchewan, the Co-operative Commonwealth Federation government led by Tommy Douglas, who is often referred to as the "Father of Medicare," had already set up a universal health insurance plan in the early 1960s. Douglas subsequently became the leader of the federal NDP, in which capacity he continued to be an influential supporter of a nationwide healthcare plan.

4 However, an expert referee for this *Commentary* has suggested that in a hypothetical situation where most physicians limit their practice to patients who pay for their services privately (outside the provincial plan), a province might be charged with having contravened the "accessibility" condition in the CHA.

5 The regulation of private funding for publicly insured medical services is generally broken up into two parts – one applies to physicians who opt out of the public system while the other deals with doctors who remain but want to generate some private funding as well. Most provinces, including Ontario, Manitoba, Nova Scotia, British Columbia, Alberta, Québec, Saskatchewan and Newfoundland and Labrador, have regulations that make it extremely difficult for physicians to remain in the public system while running a "dual practice" (Boychuk 2008).

Table 1: Regulatory Constraints for Private Funding of Medical Services in Canadian Provinces, For Physicians Who Opt-out and Opt-in.

Potential for Private Funding of Medical Services – Opted Out Physicians				
Opting Out Prohibited	**Limits on Fees**	**Public Coverage Denied and Private Insurance Ban**	**Public Coverage Denied or Private Insurance Ban**	**No Restrictions**
Ontario	Manitoba Nova Scotia	British Columbia Alberta Québec	Saskatchewan New Brunswick Prince Edward Island	Newfoundland and Labrador
Potential for Private Funding of Medical Services – Opted In Physicians				
Prohibit Direct Patient Billing	**Ban Extra-Billing**	**Ban on Private Insurance**	**Public Coverage Denied**	**No Restrictions**
Saskatchewan Manitoba Ontario Québec Nova Scotia Newfoundland and Labrador	British Columbia Alberta	Prince Edward Island	New Brunswick	

Source: Boychuk (2008). Reproduced with permission of the author.

would remain the main healthcare funding channel and to remove barriers against access for those with limited financial means (Bliss 2010). Restrictions of this kind, however, are not regarded as necessary elements of universal government health insurance coverage elsewhere. There are many examples of healthcare systems that subscribe to the principle that all residents be guaranteed access to needed care, regardless of ability to pay, but in which the rules regarding private insurance or services provision outside the public system are much looser than in Canada.

International Financing Models

This section considers the healthcare financing design in four countries – the UK, Australia, Switzerland and the Netherlands – that are generally considered to be among the world's best-performing health systems, according to the Commonwealth Fund (2014). These countries have differing financing systems that have evolved over time and are worth studying because their guiding principles are similar to those within the Canadian healthcare system. All endorse: 1) universal public coverage and access for a defined core set of services; 2) the belief that costs should be borne by society at large (social solidarity); and 3) high standards of care.

United Kingdom

Healthcare in the UK, provided by the National Health Service (NHS), is financed mainly from

general government revenue. The NHS pays for universal coverage for doctor and hospital services, as well as drugs, subject only to minor user charges. General practitioners are paid largely by capitation (per patient on a roster) and act as gatekeepers to the system: they decide the care paths that patients will take, meaning that specialist and hospital services paid for by the NHS cannot be accessed without a GP referral.

However, UK residents who want health services outside the NHS may also buy private insurance coverage against the cost of private services. Private hospitals may offer healthcare services to individuals who are willing to pay out of pocket or have private insurance. Preferential tax treatment or rebates are not offered for those who purchase private health insurance, but about 12 percent of the population owns some type of private health insurance (Foubister et al. 2006).

UK specialist physicians may run parallel private practices and work as salaried NHS employees at the same time. Private practice is permitted, without an earnings limit, provided that specialists work at least 40 hours per week under their NHS contract. Physicians may choose to opt-out of the NHS system entirely as well, though this is a rare occurrence.

There is insufficient data to estimate the weight of private financial sources by healthcare service provider, although we believe that a roughly 85 percent public to 15 percent private split is likely common across all major services, such as hospitals, doctors and drugs (Table 2).

Australia

There are three basic components to Australia's healthcare financing scheme.[6] There is public coverage for medicare (most family doctor, hospital and specialist services), a national Pharmaceutical Benefits Scheme (PBS) for drugs and a 30 percent subsidy for the purchase of private health insurance.

Medicare and PBS are intended to allow universal access to care, irrespective of ability to pay, by subsidizing access to physician and hospital services as well as drugs. They are financed through general taxes and levies. Although there are user charges, the public plans reimburse patients for most of the cost of doctor visits as well as all in-hospital costs when a patient is treated as a public patient in a public hospital. All residents are eligible for coverage under the public plan.

There is also a large private health insurance market, with more than 40 percent of Australians having a private plan (PHIAC 2013). Private insurance is purchased to help cover some of the charges that are not covered under the universal health and drug plans, but some private plans also enhance patients' care choices. Specifically, they may subsidize the cost of being treated in a private hospital, something not covered under the public plan.

Moreover, private insurance will also pay a large share of the cost when a patient chooses to be treated as a private patient in a public hospital. One reason many people choose this option is that private patients can choose which specialist will treat them when hospitalized. Public patients do not have that right and will be treated by whichever doctor is on duty at the time. Private health insurance, therefore, acts as both a parallel and complementary insurance, in the common terminology used by OECD (Box 1). Individuals are eligible to receive a substantial government subsidy when they purchase private insurance. And like in the UK, Australian

6 Relative to most OECD countries, the public share of Australia's health costs is near average, about 70 percent, and similar to that in Canada. But when this figure is broken down by service, we observe that Australia offers a much smaller share of public financing for hospitals and doctors than Canada, while Australian governments pay a larger share of overall drug costs than is the case here (Table 2).

Table 2: Public-Private Financing Mix in Selected International Health Systems, 2011

Country	Activity	Source of Finance	
		Public	Private
		percent of total health spending, 2011	
Canada	Total	70	30
	Hospital	92	8
	Doctors	99	1
	Medical Goods (drugs and other out-patient costs)	35	65
	Type of private insurance	• supplementary	
UK	Total	83	17
	Hospital	N/A	N/A
	Doctors	N/A	N/A
	Medical Goods (drugs and other out-patient costs)	N/A	N/A
	Type of private insurance	• parallel and complementary	
Switzerland	Total	65	35
	Hospital	79	21
	Doctors	60	40
	Medical Goods (drugs and other out-patient costs)	67	33
	Type of private insurance	• primary, though publicly mandated • supplementary/parallel	
Australia	Total	68	32
	Hospital	79	21
	Doctors	74	26
	Medical Goods (drugs and other out-patient costs)	45	55
	Type of private insurance	• parallel and supplementary	
Netherlands	Total	85	15
	Hospital	90	10
	Doctors	90	10
	Medical Goods (drugs and other out-patient costs)	69	31
	Type of private insurance	• primary, though publicly mandated • supplementary	

Sources: OECD Health Statistics and authors' calculations.

Box 1: Common Types of Private Healthcare Insurance

A set of standard terms is used to describe different forms of private healthcare insurance, including primary, parallel, substitute, supplementary and complementary. Primary private insurance exists when private insurance is the main vehicle by which individuals access healthcare services, as in the US. It also exists when governments mandate the purchase of insurance in law, as in Switzerland or Holland. Parallel private insurance exists when it is purchased for similar services as those covered under public health insurance plans.* Substitute private insurance is similar to parallel private insurance, though it does imply that individuals can opt-out of public coverage when they purchase private coverage, as in the Medicare Advantage plan for seniors. Supplementary private insurance exists for services not covered under public health plans, which is the essential role for private insurance in Canada where public health insurance often does not cover drugs, dental, optical services as well as physiotherapy and long-term care. Complementary private insurance is intended mainly as a top-up to publicly insured services, often covering user fees or deductibles associated with the delivery of publicly covered services.

* Private parallel insurance is referred to as voluntary supplementary private insurance in Foubister et al. (2006), demonstrating the widely varying use of terminology for insurance markets in the health policy literature.

doctors can operate dual practices and provide services for patients covered by both public and private insurers' plans.

Switzerland

In Switzerland, the government requires all citizens to purchase one of many competing eligible insurance plans, each one of which must cover a specified minimum bundle of health services, including most physician and hospital services, drugs and dental care, as well as psychotherapy. A plan may also offer coverage beyond the specified minimum, and insurers compete both in terms of the premiums they charge and in the range of services they cover.

Private insurance companies offer these compulsory insurance plans and must set flat premiums to all individuals across designated geographic regions. Premiums may not vary by income or individual health risk.[7] The federal government offers means-tested subsidies to help low-income individuals pay annual premiums.

Individuals are allowed to choose among available insurance providers and may switch providers twice per year. The government caps premium levels to ensure that they are within specified limits.[8]

7 Insurers have a fund through which transfers are made to those companies whose enrollees have higher-than-average expected healthcare costs due to factors such as age, prior hospitalization, etc. Although this approach is similar to the risk-adjustment model used in the Netherlands, it is not as highly developed.

8 Roughly two-thirds of Switzerland's health costs are paid for publicly. However, this statistic includes the individual premiums paid to private insurers for the specified minimum compulsory insurance. While some 80 percent of Swiss hospital costs are paid publicly, Switzerland has a much lower share of physician costs paid publicly than in Canada – 60 percent versus roughly 99 percent (Table 2).

Under the mandatory plans, patients have restricted choice over health providers, and costs covered by insurers must not exceed set levels. Only cost-effective and clinically effective treatments are insured under the specified mandatory coverage. With government acting as a dispute-resolving body, insurer associations negotiate with providers over a nationwide fee schedule for services. While insurance providers reimburse patients for the costs of hospital services and physician fees, the patients must pay deductibles and co-payments on almost every health service. Complementary insurance coverage to cover these user costs does not exist; it is generally prohibited under the terms of the different mandatory plans.

About one-third of the Swiss population has voluntary supplementary insurance for coverage beyond the regulated minimum (OECD 2011). Often, this means insurance that allows for free choice of physician as well as access to superior in-patient services, such as private hospital accommodation. Physicians in Switzerland are allowed to extra-bill under these plans. Essentially, patients with non-compulsory insurance have quasi-parallel plans that may also cover services that are not considered cost-effective, but that they want in any case. However, there has been a declining interest in supplementary/parallel coverage over time as the bundle of services offered under the compulsory minimum plans has grown.

The Netherlands

In 2006, the Netherlands dramatically reformed the financing of its national healthcare system. Before then, only high-income individuals were allowed to opt out of the basic social health insurance plan and acquire private insurance instead. After the reforms, everyone must be covered by one of many eligible basic plans, but may have voluntary supplementary coverage as well.[9]

The Netherlands health insurance system has three major components – long-term care, basic and essential medical care (GP visits, hospital and specialist services, as well as drugs) and supplementary coverage for less essential services, such as dental care, physiotherapy and vision care. All citizens must purchase basic universal coverage from a list of eligible insurance providers. As in Switzerland, the individual premiums charged by an insurer must not vary based on the specific risks of a patient, and insurers cannot turn away individual purchasers of the basic plan. Also, eligible plans must offer coverage for a specified package of services. Low-income individuals are provided with a government allowance to pay for the purchase of basic universal health insurance.

Government also levies income-related contributions on everyone for a national risk-adjustment fund from which it pays an annual subsidy to all insurance plans based on enrolment and the health of the enrolees. The yearly subsidy per individual is set to reflect his or her expected healthcare costs, based on factors such as age, sex, previous illness history, chronic conditions, etc. This reduces insurers' incentive to circumvent the rules and discriminate against high-risk individuals when designing and marketing their plans.

Insurance companies negotiate directly with providers to determine fees and ensure quality of care. Consumers are encouraged to choose among

9 While many of the eligible basic plans are offered by private insurers, international statistical agencies generally have not included their payments as part of the private share of Dutch healthcare costs. Instead, they have focused on the fact that citizens are mandated to purchase insurance – which is similar to taxing individuals to pay for insurance under a public plan – and that a large part of health spending flows through a public fund (for risk adjustments). Consequently, the figures show the public sector as paying the vast majority of all health costs (Table 2).

insurers according to premium differences and supplementary insurance, which exists separately from the basic coverage. They may choose to switch insurance plans each year.

Voluntary supplementary private insurance exists for all non-basic health services, and around 90 percent of Dutch citizens have purchased such coverage (Netherlands 2011). Insurers that offer statutory, basic medical insurance also offer supplementary insurance. Most people buy supplementary coverage from the same insurer who provides their basic coverage, but they are able to buy an assortment of supplementary coverage from many providers, which may improve their chances of getting faster access to care.

Canada's Single-Payer Model

In comparison with the countries reviewed above, Canada's system does not have a particularly low share of private financing. The main reason for this, however, is that Canada's provincial health insurance plans are narrow in scope so that private payment still dominates in the financing of items such as outpatient drugs, non-acute long-term care, and dental and vision care. With respect to physician and hospital services, Canada can reasonably be described as having a "single-payer" system, with almost no role for private payment. For providers of these services, there is effectively only one source of revenue, namely the provincial insurance plan, though there are some exceptions such as provincial worker compensation plans. For residents of Canada, the provincial plan is the only option if they want insurance that covers physician and hospital services.

The restrictive rules both with respect to private health insurance and the offering of health services outside the provincial plans makes Canada unique, not just in comparison with the US but also with countries like Australia, the Netherlands, or even the UK. To defenders of the Canadian model, however, any movement away from the status quo in this respect will seem misguided or worse.

Arguments for the Single-payer Model: Efficiency and Cost

To many of those who most strongly support the single-payer model, its most important characteristic is that it promotes equitable access to healthcare. However, it can also be supported on the grounds that it is better able to control aggregate healthcare costs than a system of multiple payers.

One straightforward explanation why a single-payer system can be less wasteful than one with multiple funding sources is that it is less costly to administer. Administrative costs with multiple payers include not only those in the insurance industry itself, but also the indirect costs borne by providers having to deal with many different insurance plans.

The high administrative costs in private insurance are partly due to the fact that insurers spend a lot of resources trying to identify groups of individuals with low expected healthcare costs, whom they then try to attract by offering them preferential premium rates. However, risk-differentiated insurance premiums are regarded as inequitable by most people. They may also give rise to the problem known as *adverse selection* because they give high-risk individuals an incentive to conceal information about their ill health. Adverse selection is economically inefficient[10] but there are regulatory approaches that can be used to overcome it even in multiple-payer models where private

10 It tends to drive relatively generous insurance plans out of the market because these plans disproportionately attract people with high expected healthcare costs. It is this effect that implies inefficiency in the sense of economic theory: People who would prefer plans with generous coverage are made worse off as a result of adverse selection.

insurance continues to play a major role, as the Swiss and Dutch systems illustrate.

Another argument in favour of a single-payer system is that it may lower aggregate healthcare costs by reducing the prices for physician and hospital services as well as other health sector inputs such as drugs. The US approach, lacking a single payer that dominates the buyer's side of health services markets, is cited as one explanation of why its healthcare system is so much more expensive than those in other countries (Anderson et al. 2003).

However, the question in this *Commentary* is not whether Canadians would be better off in a US-style system, but rather whether a case can be made for policies that allow private insurance and services outside the provincial plans to play a somewhat larger role than they currently do, along lines similar to those in the other countries discussed earlier. Even if such policies were pursued, the provincial government plans would remain the largest player on the buyer's side for the foreseeable future and would certainly retain enough market power to bargain effectively with providers.[11]

The Single-payer Model and Equity

The most spirited arguments in favour of a single-payer model, however, do not concern its efficiency. Instead, they relate to the notion that it is more equitable than a system with multiple payers where those who are willing and able to pay extra can get access to better care, and get it faster, than those who are not. Canadians generally favour a healthcare system where the resources spent on treatment of a given type of health problem should depend solely on the patient's need and not on his or her ability to pay.[12]

As further discussed below, a difficulty with this ideal is that the concept of "need" in healthcare is not always well-defined, so that the principle that healthcare should be supplied strictly according to need is difficult to apply in practice. Moreover, responses to survey questions on this kind of issue may depend on how respondents interpret them. Most Canadians would probably agree that the well-to-do should not be allowed to pay for faster access to care if the result is longer waiting times for those who cannot pay, but fewer might object if there is no effect, or even an improvement in the form of shorter waiting times in the public system.

In Canada, the idea that wealthy people circumvent the restrictions on privately financed medicine by going to the US does not provoke nearly the same level of indignation as stories that individuals with good connections are able to jump the queue. Indeed, queue-jumping for elective surgery can lengthen the wait for others on the list, but leaving the lineup for the US shortens the wait time for those who stay.[13]

While some of those who support restrictions on privately financed medicine do so on principle,

11 In the Swiss and Dutch systems, costs such as physician fees and nurses' wages are typically negotiated centrally, between organizations representing the insurers on the one hand and groups such as physician associations or nurses' unions on the other. In such central negotiations, or in cases when provider collectives negotiate with a single government plan as in Canada, the provider organizations have a high degree of countervailing market power, reducing the buyers' ability to keep healthcare costs low.

12 As is often argued in Canada, a single-payer system eliminates "two-tier healthcare," which was a major discussion point in the final report of the Romanow Commission (2002).

13 Both these kinds of queue jumping exist in Canada. As Bliss (2010) puts it, "Nothing short of a lottery-like approach to healthcare rationing could prevent the well-educated and savvy from doing a superior job of gaming the system on behalf of themselves, their families, and their friends – and even then the rich would still be able to jump the queue by crossing the border" (p.12).

others who favour such restrictions see them as an indirect method of redistributing real income to the poor. Specifically, the argument is that when all citizens are compelled to share the same healthcare system, taxpayers are indirectly paying for better healthcare for the poor than what the poor would be able to pay for on their own. Thus, the reasoning goes, the average real income of the poor is higher as a result.

This argument sounds plausible, but in practice the Canadian healthcare system is, at best, only marginally progressive in terms of redistributing real income (Glied 2008). Furthermore, the issue of equity in our health system has been such a dominant theme in Canadian social policy that other kinds of support for the poor may have been neglected in comparison.

Does a Single-payer System Really Help the Poor?

Because Canada is a wealthy country and has a population with a highly developed sense of social solidarity, one might expect the standard of living among the poor in general to compare favourably with that in other countries. As elsewhere, however, the extent to which the poor are supported by tax-financed redistribution is, when all is said and done, limited by the willingness of taxpayers, through elected representatives, to pay for it.

The relevant question in the present context is, if taxes are used to pay for a common healthcare system that covers everyone, and the costs of this system regularly grow much faster than the tax base, does this reduce taxpayers' willingness to pay for other kinds of transfer programs that benefit the poor, such as social assistance and refundable tax credits? If the answer is yes, the case in favour of a common single-payer system obviously is weakened. From 1990/91 to 2013/14, total provincial and territorial healthcare costs have risen as a share of total program spending from 34 percent to 41 percent. To put it in another way, all other programs, such as education and social assistance, now make up a much smaller share of provincial and territorial spending than before. Measures to support the poor and vulnerable may have lost out to healthcare in the competition for public funds (Glied 2008).[14]

Is the Single-payer Model Outdated?

To be considered equitable, a society must redistribute income so that the poor can enjoy an acceptable standard of living and have access to high-quality medical care. What is questionable, however, is whether, on balance, these broad equity goals are well served by a single-payer system to which everyone must belong and which effectively eliminates opportunities for choice with respect to how people want to be treated when they are ill. Although it is possible that the restrictions on private insurance and medicine could be justified as a political strategy during a sensitive stage in the development of our universal healthcare system, they may have outlived their usefulness. The relevant question today is whether Canadian provinces should pursue policies that leave at least some room for competition between public healthcare plans and private insurance that either complements or substitutes for the public plans, along lines similar to those in the countries discussed earlier.

14 Social assistance is one provincial program where it is relatively easy to reduce costs by restricting entitlements or tightening eligibility rules (Kneebone and White 2014). In contrast to healthcare, the federal government makes few efforts to impose standards on the way the provinces manage social assistance spending, perhaps partly because there are no clearly identifiable interest groups on the production side who stand to benefit from increased program spending.

Healthcare, Choice and Medical Technology

The idea that health resources should be allocated strictly according to need is appealing, but it presupposes that need can be defined in a precise and widely acceptable way. In some cases, it can. For health problems where lack of treatment would have serious consequences and there is a single effective treatment approach or drug that will cure the patient with certainty, or with a high probability, it is clear what is needed. But most health issues are not like that. In some cases, there is a reasonable probability that the problem will resolve itself without treatment, so delay is an option.[15] More importantly, for many conditions, there are many possible treatment options (or drugs) that differ somewhat in the probability that they will be effective, or in the likelihood of side effects of varying degrees of severity. In such cases, the concept of need clearly is not well defined. However, the cost of dealing with given patient populations will likely differ substantially depending on what options are chosen.

As Canada's health-financing system was being developed in the 1960s and 1970s, the range of treatment options and drugs was much more limited than today. At the time, it may not have been unreasonable to ignore the problem of controlling costs and simply allow doctors to make the decisions about what was needed, regardless of cost. But as medical and pharmaceutical research has continued to create new and sometimes very expensive treatment options, this strategy has become more and more untenable.

For provincial governments, advancing medical technology makes it difficult politically to control costs. If they try to do so by restricting access to new technologies, there will be complaints that needed health services are being "rationed." And there will be pressure from providers and well-to-do patients to allow for such treatment to be paid for privately, outside the provincial plan. But defenders of the single-payer system will urge governments to either give everyone access to the expensive treatment options (which ultimately becomes too costly) or prevent anyone from using them. This, as we see it, is the fundamental long-term dilemma of our current single-payer system.

Equity and Provider Incentives

In the short and medium term, there are some less draconian ways than rationing to control costs. Evidence from the US and elsewhere indicates that some costs can be influenced substantially by careful attention to the incentives to which providers, rather than patients, are subject. For example, primary-care doctors whose income comes mainly through salary or capitation are more likely to make cost-effective choices for their patients than those who are paid through fee for service (Blomqvist and Busby 2012b). Similarly, the cost of providing a range of hospital services for a given population is likely to be lower if hospitals are financed through some form of activity-based funding rather than strictly through lump-sum budgets (Blomqvist and Busby 2013). What is common for these alternative methods of paying providers is that they imply

15 For example, "watchful waiting" is increasingly the preferred strategy for males diagnosed with prostate cancer, many of whom will never undergo invasive treatment. As another example, it can be argued that mass screening programs for certain kinds of cancer will do more harm than good for patients in certain age categories, principally because the consequences of expensive retesting or side effects of invasive treatment when there are false positives outweigh the benefits of a small number of early detections. In a controversial guideline, the Canadian Task Force on Preventive Health Care used this logic to recommend against routine use of the PSA test for prostate cancer (*Globe and Mail*, Oct. 27, 2014).

at least some degree of incentive for them to pay attention to the cost of the services they supply (including the implicit cost of their own time, in the case of doctors), rather than just to the possible benefits to the patients.[16]

However, controlling costs by such incentive methods would also be controversial. While taxpayers will appreciate the reduced costs, some patients may be uncomfortable at the thought of being treated by a provider with an incentive to keep costs low. Once again, this presents provincial governments with a dilemma. If they try to control costs by introducing compensation methods of this kind, there will be pressure to allow patients to get care outside the provincial plan from providers who do not face such incentives. On the other hand, those who defend the single-payer system will insist that allowing this to occur is inequitable.[17]

Addressing these dilemmas requires questioning our model of provincial health insurance monopolies. As an alternative, we should start thinking seriously about a system that provides at least some degree of choice but that also remains consistent with the fundamental Canadian values of equity and social justice.

Monopolies, Whether Private or Public, Do not Give People Choices

In economic analysis, a fundamental question with respect to any kind of activity is, can it be organized in such a way that consumers benefit from being able to choose among competing providers of the good or service? If the answer is no, the activity is referred to as a natural monopoly, and the responsibility for carrying it out must be given to a single firm or public agency. But allowing a sector to be run by a monopoly is fraught with problems.

In cases where the monopoly seller is an unregulated for-profit firm or group of firms, the result is the textbook problem of very high prices. However, monopoly positions for non-profit firms, or even public agencies, may hurt consumers as well. Costs may be inflated if groups that control critical inputs of the production process are able to negotiate favourable terms for supplying their services; in healthcare, provincial medical associations that represent the interests of physicians come to mind, or labour unions representing nurses and other hospital employees.

More importantly, managers of public agencies or non-profit healthcare providers do not face the same pressure as managers in for-profit firms to innovate and deploy their resources efficiently, since they do not have to directly compete with other sellers on either price or quality. In a mixed system, in contrast, private insurance plans can survive only if their clients receive high-quality care at reasonable cost, and managers of the public plan have at least some incentive to respond to defend their market share.

Technically, Canada's single-payer provincial health insurance plans do not qualify as monopolies in the health services markets, since there are many physicians and hospitals that provide the services patients receive. But they are monopolies

16 With capitation in primary care, providers have an incentive to control the average volume of services that a given patient population receives and the cost per unit of such services. With activity-based funding, the total amounts that a hospital receives rises with the volume of services performed (that is, the number of procedures of various kinds), so if the payment per procedure is high enough, hospitals do not have an incentive to limit services volumes. However, since the amount of funding per procedure typically is fixed, they do have an incentive to control the cost per procedure.

17 Again, this may be cited as an instance of the detrimental effects of the Canadian pre-occupation with equity in healthcare, specifically, rather than with the real income of the poor, generally. For example, attempts at introducing more efficient methods for compensating doctors have been resisted partly on the grounds that such methods would have to apply to all providers to ensure that the incentives on their providers are the same for all patients.

as intermediaries between patients and providers. Almost all physician services are supplied according to terms that have been negotiated between the provincial plan and the provincial medical association, and hospitals, while private, provide all their services to patients in return for the funding they receive from the provincial plans.[18]

Since the plans are public (and hence non-profit) agencies, they do not have an incentive to make money for their shareholders. But like other non-profit monopolies, while they are subject to pressure from those who supply their inputs, they do not face strong incentives to control costs through innovation since there are no competitors nipping at their heels. Accordingly, measures to allow more options for private financing of healthcare could potentially reduce the market power of the provincial plans and their service suppliers, and create incentives for organizing the delivery of health services in more cost-effective ways.

Allowing some degree of competition among sellers is also likely to be advantageous when individuals differ in their valuation of the goods and services to be supplied. Even when it is possible in principle to provide different goods and services to different consumers, a monopoly provider may not find it worthwhile to do so, especially if it is a public non-profit agency. Developing and supplying variety is costly, and when there is no competition, a monopolist may find it easier to offer consumers only a single version.[19]

Again, there are many in Canada who still believe that the monopoly model is the right choice for reasons of equity. But based on other countries' experience, it is possible to design a system that both remains consistent with the basic objective of equitable access to healthcare and gives individuals some degree of choice to make different tradeoffs between their health insurance coverage and other goods and services that they also value.

Toward a Pluralistic System: The UK Model

The Canadian and UK health-financing systems are similar in many respects (the UK NHS is sometimes also described as a single-payer model), but there are major differences as well. One major distinction is the degree to which the NHS pays for drugs. Another is that the UK rules on supplying medical care outside the public system are considerably less restrictive than in Canada. Furthermore, as discussed earlier, in the UK there is a small market for private health insurance, some of which covers the same services as are available through the NHS. The first step toward a Canadian model that would offer a bit more choice and competition should be for the provinces to loosen the existing restrictions on the provision of physician and hospital services outside the provincial plans and on the types of private health insurance plans that can legally be offered, along lines similar to those in the UK system.

Allowing Dual Practice and Private Insurance

The term "dual practice" is used in countries where physicians are allowed to provide services both under the government plan and privately. In most Canadian provinces, it is not allowed, so that a doctor that bills the provincial plan for services

18 Since patients in Canada can generally choose which physician or hospital to go to, there is some degree of competition among providers. However, this competition relates only to perceived service quality; there is no competition with respect to prices (fees) that providers charge.

19 According to an oft-cited anecdote, when the Model T Ford dominated the market for passenger cars, Henry Ford is supposed to have said that buyers could have any colour they liked, as long as it was black.

performed under it cannot also get paid privately for treating patients outside the plan. In many other countries, dual practice is allowed and quite common. For example, US physicians who treat patients under the public Medicare and Medicaid plans also treat other patients, but it is also common in the UK and Australia, where many specialist doctors spend part of their time treating patients under the government plans (for which they typically are paid a salary) and also have private practices where they are paid on the basis of fee for service by their patients or insurers.

Some hospitals in both these countries also may provide services to patients either under the public plan or in return for private payment, but services outside the public plans are also provided in private hospitals. Both countries allow insurers to sell plans that pay part or all of the cost of services utilized by private patients. We think Canada's provinces should follow these examples.[20]

A common argument against allowing more private insurance and health services production outside the public plan is that it would result in many doctors and hospital beds diverted to providing care for these private patients (Flood, Stabile and Kontic 2005, CHSRF 2005). This would lead to fewer resources for the public plan, so the argument goes, both directly and indirectly. Directly, fewer doctors and beds would be available for the public plan and, indirectly, the opportunities for doctors and hospitals to earn revenue in private markets would force the public plan to pay more per unit for physician services and hospital beds, resulting in cutbacks. And with fewer resources, the quality of care in the public plan would suffer.

We believe that this fear is overstated, for several reasons. Allowing individuals to pay for care privately would not necessarily result in a large net increase in the demand for physician and hospital services. Most of the care that would be produced outside the public plan would otherwise have been demanded inside it. As a result, even if some doctors and nurses were to move to the private market, or hospitals were to devote some beds to private patients, this would not necessarily imply any significant decrease in the amounts available per patient who remained in the public plan.[21]

Second, increased use of resources to produce privately financed medicine need not result in reduced availability of services under the public plan if there is slack in the system.[22] Indeed, there is evidence that many healthcare resources in Canada, including labour, are underutilized. As medical schools and universities have produced large numbers of doctors and other health professionals over the last decade, not all of these individuals have been able to find full-time work, and many would like to work more but are not able to (Fréchette et al. 2013). A parallel private market with more flexible pricing and wages than in the public system might enable us to make use of idle resources such as underemployed physicians whose hours are restricted by hospital capacity constraints (Fréchette et al. 2013). In such cases, allowing private production may lead to more flexible and efficient resource management, including more intensive use

20 Eloquent statements against this recommendation can be found in essays in Flood, Sossin and Roach (2005).

21 An expert referee has observed that there is a tendency in the UK and Australia for private medicine to focus on low-cost, routine services, leaving the more complex and costly cases to the public sector. While this will tend to raise the average cost per case in the public system, it also means that the amount of manpower and other resources that are diverted to the private sector is smaller, other things being equal.

22 The positive correlation observed internationally between the length of public sector waiting lists and the availability of private insurance (Duckett 2005; Besley, Hall and Preston 1998) is arguably not well understood. It is entirely plausible that deficiencies in public plans are leading to a higher take-up of private insurance – not the other way around. More importantly, changes in the relationship over time, as a response to changes in policy, have been generally unexplored.

of hospital facilities such as operating rooms that are not being used outside regular hours because the hospitals do not have enough money to pay for the required personnel.

The concern over losing public resources to the private sector has proven manageable in the UK, even though a considerable amount of physician and hospital services are produced and paid for outside the NHS. While NHS specialists have been allowed to practise privately on the side, they have been subject to several restrictions when doing so. One is that they must complete their regular work week – at least 40 hours – within the NHS before they can practise privately. Another is that there have been ceilings on the fees that they can charge patients in their private practices.[23]

Despite the potential positive short-run impacts on the public plan, we think it is unrealistic to expect an immediate reduction in public sector wait times as a result of allowing more room for private medicine and health insurance. A reduction in wait times would also require a suite of reforms in the public plans. However, a significant number of individuals opting for private care due to deficiencies in publicly available care could act as a catalyst for those reforms to come about.

Longer Run Effects on Public Plan Quality

In the long run, the main determinant of the quality of care offered under the public plan is the amount of resources that taxpayers, through the governments they elect, are willing to make available, and we see no reason why that amount would be reduced because more people had chosen to receive their care in the private market. In any case, our main argument is that the existence of the private plan should increase incentives for the public plan to improve over time.

We expect that more scope for health services to be produced in private markets would have a favourable effect on the quality of care inside the public plan: it would expose public plan managers to some degree of competition, especially as payments to hospitals shift to more closely reflect the volume and quality of services produced.

In the present system, the provincial plans have an effective monopoly. As a result, consumers/patients cannot use an "exit option" as a way to let the public plan managers know that there are aspects of the plan that they are not satisfied with, such as long wait times for some procedures and tests, crowded emergency rooms as the only available option to get access to urgently needed primary care, or a lack of attention to hospital patients' convenience and comfort.

With more access to private insurance and health services markets, more people would have an exit option, and it would seem reasonable to expect that if larger numbers of people began to exercise it the result would be more political pressure on the public plans' managers to raise the quality of care offered, not reduce it.

The UK experience may be interpreted along these lines. The UK healthcare system of course is different from Canada's not only with respect to the rules governing the production of health services outside of the NHS, but in a number of other important ways as well; some of these are briefly discussed in Box 2. Nevertheless, UK's solid international ranking is consistent with the idea that it is possible to manage a healthcare system in ways that are both equitable and efficient, while leaving considerably more room for private services production and insurance than allowed in Canada.

23 The latter measure, which has been used elsewhere, is in part also designed to reduce the incentive for "moonlighting" physicians to boost their income by referring public patients to their private practices (Biglaiser and Ma 2007).

Private Medicine and Insurance: How Slippery is the Slope?

The optimistic scenario on which this *Commentary*'s main recommendations are based is a future Canadian healthcare system in which a share of hospital and physician services are produced outside the provincial plans and paid for in part by private insurance. It is inspired by examples such as the UK and Australia, whose systems continue to be dominated by government financing, and do not seem to be in danger of morphing into a US-style model.

In discussions of the legislative changes required to realize this scenario, many commentators have stoked fears that loosening restrictions on private insurance and medicine would lead to radical changes and undermine the basic principles on which the Canadian system is based (Marchildon 2005, Maynard 2005). Predictions of this kind were made around the time of the Chaoulli decision, which overruled some restrictions on private practice and private payments in Quebec, but no significant private insurance market has emerged in that province a decade later.

With the benefit of hindsight, this is perhaps not surprising. Even with the problems that some patients have experienced with primary care access and long waits for some diagnostic and treatment procedures, not many people are willing to pay privately for insurance coverage that they already have under the provincial plan. Potential market entrants also feared regulatory hurdles that the provincial government could put up to discourage private insurance even if it could not ban it outright. They worried about the cost of underwriting that would be necessary to avoid attracting too many people with pre-existing health problems. Therefore, our scenario might be too optimistic because it overestimates the willingness and ability of private insurers to find enough subscribers to justify entering the market, rather than the other way around.

Loosening the rules on dual practice might produce more of a supply response in the short run, partly because some of the patients who would otherwise go to the US for faster treatment might then have an opportunity to pay for and receive quick access in Canada. Private insurance and increased opportunities for dual public-private practice complement each other, so that creation of viable private competition for the public plans would be more likely if restrictions are relaxed on both. Dire predictions to the contrary, we do not think there is any reason to believe that such competition would lead to a rapid disintegration of the current system. Private medicine and insurance would grow slowly over time and there would be plenty of opportunities for public policy to respond by strengthening the provincial plans, along the lines we envisage.

The Longer Run: Public-private Competition on More Equal Terms?

Health policy is controversial and involves strongly held views, so health system reform in any country at best proceeds gradually and incrementally. For the foreseeable future, therefore, Canada's health-financing system will continue to be dominated by the provincial plans, and the role for private insurance would grow slowly even if provincial governments relax the restrictions that currently limit it, and the restrictions on the supply of medical services outside the government plans. If this were to happen, Canada's future healthcare system would more likely become somewhat similar to the current UK model than to the very different ones used in countries like the Netherlands or Switzerland.

As observed in Box 2, the UK health system, in spite of its many flaws, has a well-functioning primary care sector with sensible incentives for GPs to manage their patients in a cost-effective manner, and its mixed public-private model of secondary care, though often a source of debate, seems to operate reasonably efficiently. Even though it costs considerably less per capita than the Canadian system, the UK public plan covers prescription drugs, which Canada's provincial plans do not.

Box 2: The UK Healthcare System as a Model for Canada

Earlier C. D. Howe *Commentaries* have discussed various features of the UK healthcare system that could serve as models for Canadian reform (Blomqvist and Busby 2012a, 2012b, 2013). These are:

- Primary care in which each resident must register with a GP practice that will serve as his or her "medical home" during the contract period. GPs have a gate-keeping role, meaning that patients' access to secondary care and covered prescription drugs is controlled by their GPs' prescriptions or referrals. GPs are paid largely via capitation, that is, fixed monthly sums for each patient for whom they are responsible, regardless of what services the patient has received. Capitation implies an incentive for GPs to make effective use of non-physician care providers in their practices;
- Compensation of hospital-based specialist doctors by means of a salary that comes out of the budgets of the hospitals where they are employed. Most specialists' contracts allow them to practise privately one the side, as discussed in the text; and
- Comprehensive coverage that includes outpatient drugs and most of the costs of long-term care.

UK hospitals continue to be owned by the NHS and funded in large measure through negotiated budgets, a model similar to that used by Canada's provinces. However, most UK hospitals are now managed as semi-independent "hospital trusts," and more of their funding over time has been coming through contracts negotiated in "internal markets" where the hospitals "sell" their services to agencies that act as purchasers of care on behalf of defined populations.

In the 1990s, the purchasers were mostly regional government agencies that were responsible for arranging secondary care in their districts. More recently, the purchasing role has increasingly been taken over by GP practices. Under the model of "practice-based commissioning," the GP practices have been allocated budgets from the NHS to negotiate in advance with hospitals for the secondary care that the hospitals will produce for the patients that are registered with the practices.

Since patients can choose with which GP practice to register, GPs compete for patients to some extent. They have, therefore, begun to function somewhat like small insurance plans, along lines similar to those among which residents in the Dutch systems can choose. UK residents can typically select from a number of different local GP practices, and while there is no competition in the price dimension, they can choose the one that they believe will offer the best value. Over time, the UK and Dutch systems appear to have become similar in many ways. Both now offer all citizens coverage on similar terms, regardless of ability to pay or expected healthcare costs, and both are trying to make use of markets and competition to make their healthcare systems operate more efficiently.

The difficult decisions that created the UK NHS model (to move from fee for service to capitation for family doctors, to require patients to register with a gate-keeping physician and to pay hospital-based specialists via salary) were made at the end of the Second World War by a national government with a clear mandate to restructure UK social policy. In Canada today, neither the federal nor the provincial governments have such a mandate, and opponents can exploit the system of divided federal-provincial jurisdiction over health policy to block reform measures they do not like. With little prospect of governments and politicians being willing to initiate meaningful reform, more competition from private alternatives may represent the only, or at least a more promising, approach to creating pressure to improve the public system.

Relaxing the restrictions on private production of health services and parallel private insurance to make the Canadian health framework similar to the UK's, would be a good first step. But the UK model has one very unattractive feature – most of those who sign up for private parallel insurance are individuals in the higher income brackets (Foubister 2006). Private provision and insurance in the UK does not compete effectively for clients in the low- or middle-income brackets, who stay with the public plan instead.

But, as discussed earlier, advancing medical technology will continue to offer more and more options for spending resources to improve health. Some of them will be very expensive, and hence force society to make difficult choices between additional healthcare spending and other goals. Making these choices collectively will only become harder, so the potential advantage of allowing most people, not just those with high income, to make them implicitly by giving them a wider choice among insurance plans will grow over time. So will the urgency of promoting innovation to create more efficient models for managing the public plans. More broadly based competition between private and public financing and provision could help accomplish this, too.

For these reasons, a health-financing model similar to the one that is developing in the Netherlands will look increasingly attractive in the long run. In the Dutch model, all providers and insurance plans compete on equal terms.[24] Under the UK model, in contrast, the public NHS plan has a huge advantage. Since it is a universal tax-financed plan, every citizen is automatically covered by it, at a zero out-of-pocket premium. Competing private plans, in contrast, have to charge out-of-pocket premiums that are high enough to cover all their expenditures, with no government subsidy.

The minority of UK residents who buy parallel private insurance are effectively paying a second time for coverage they already have under the public plan. In the circumstances, it is not surprising that private insurance in the UK is marketed mostly to high-income people and can compete only by offering coverage that is perceived as being of higher quality than what is offered in the public plan.[25]

Because the Dutch model is so different from the current Canadian system, it is clearly of limited relevance as a short-term template for health system reform. However, as it evolves over time and

24 As described above, every Dutch citizen receives a (risk-adjusted) subsidy that can be used to help purchase any one of the many eligible insurance plans. Some of these plans are offered by private insurers, while others have their origin in the non-profit sickness funds that previously covered most of the population.

25 The concept of "two-tier medicine" aptly describes what happens when competition between public and private insurance takes this form. In systems where insurers compete on more-or-less equal terms, the "two-tier" concept doesn't feature prominently in the health policy debate.

is refined, and as more countries experiment with similar reforms,[26] its appeal is likely to grow. Instead of dismissing it out of hand as the first step on the slippery slope toward a US-style healthcare system, Canadian policymakers should pay careful attention to other countries' experiments with this approach.

In particular, they should pay attention to the case of Australia, which has gone much further than the UK in allowing a substantial role for provision and financing of private medical care. Although the Australian system is similar to that in the UK in that every resident is automatically covered by the public plan, private insurance can compete with the public plan on more equal terms because it is partially subsidized by government. Implicitly, the Australian model (in contrast to that in the UK) recognizes that most of the health services that are privately paid for would otherwise have been produced and paid for under the government plan, so more private funding reduces the government's healthcare costs at least to some extent. Following the Australian example in this respect would therefore be a natural next step if Canadian provinces were to move in the direction of loosening the restriction of private provision and financing of medical care.

Concluding Thoughts

Compared to the US, Canada's less expensive and more equitable healthcare system has long, and rightly, been something to be proud of. But many other countries, in Europe and elsewhere, also have systems that cost much less than the American one and that, arguably, are at least as equitable as Canada's, if not more so. In comparison with them, Canada's unbalanced model with complete public insurance for hospitals and doctors but limited and non-universal funding for other outpatient costs is somewhat of an anomaly. No other country is modelling their health-financing system around the Canadian example, and the countries we reviewed earlier provide health services more efficiently, and no less equitably, than under Canada's provincial plans.

Equity concerns have a significant role in the political decisions made in foreign countries, too, but none of them seem to think that a monopoly approach to paying for most health services is the best way to achieve equity and efficiency goals. Many other countries allow competition among private insurers and public plans to improve individual choice over healthcare services as well as the harnessing of these choices to promote efficiency and control costs. We believe that other countries' more active pursuit of reforms to their public healthcare systems are driven, at least in part, by the existence of private options.

The *Canada Health Act* does not explicitly rule out the development of private insurance or private payments for medically necessary services. But provincial-level restrictions have created a system where, for hospitals and physicians, the public payer is more or less the sole source of income. Relaxing the provincial regulations on private income sources by physicians – such as opt-out prohibitions, limits on fees and private insurance bans – could maintain the strengths of our current system and use expanded choice and competition as a method to create better incentives for politicians, bureaucrats and providers to manage it more efficiently.

With respect to efficiency, we recognize that a single-payer model may be less expensive to

26 Israel has a health-financing system that is based on principles similar to the Dutch model, and recent reforms in Germany are moving its health-financing system in the same direction. US attempts at moving toward universal health insurance coverage under Obamacare also are based on the idea of combining universality with competition among insurance plans, whether private or public.

administer than a pluralistic one. However, a single-payer system in which doctors are expected to always use the best available medical care for every patient ultimately creates an impossible dilemma, as advancing medical technology raises the cost of doing so.

On the equity side, our single-payer system may have led to more equal healthcare between rich and poor than would have prevailed otherwise, but it arguably has made the social policy debate in Canada focus too much on healthcare to the detriment of other programs that are at least as important in helping society's most vulnerable.

We agree with those who believe that extending relatively more public coverage to areas such as outpatient drugs and long-term care should be a high priority for Canadian health policy. And we support the attempts that are being made in some provinces to get better value for money through approaches such as more use of capitation in primary care and case-based funding of hospitals. But in comparison with other countries, Canada's reform efforts, so far, have not been very successful.

Some might say that easing the restrictions on private financing of services outside provincial plans will distract us from the task of pursuing those efforts more vigorously and improve the public system. We disagree. We think it more likely that the threat of more competition from private medicine will serve as a catalyst for a political climate that applies more pressure on politicians and government officials to take this task more seriously.

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